Patient Management Module

Chest X-Ray

CHEST X-RAY

(Last, First,, Middle) CLIENT NAME:		DATE OF BIRTH: / /	Age:
SS #:	STATE CASE #:	CITY/COUNTY CASE #:	
SITE:	SPECIAL ATTENTION REQUIRED: Explain		

View: (Check one)

- **G** Posterior/Anterior
- **G** Lateral
- **G** Other_____

Date Taken: _____/____/____

By: _____ or **Where**: _____

Date Read: ____/____/_____

Read By: _____

Results: (Check one)

- **G** Normal **G** Not Done
- **G** Abnormal **G** Unknown

If abnormal,**Abnormality**: (Check one)

- **G** Cavitary
- **G** Noncavitary consistent with TB
- **G** Noncavitary*not* consistent with TB

Status: (Check one)

- **G** Stable
- **G** Worsening
- **G** Improving
- **G** Unknown

User Defined Variable Information: (If needed)

General Comments: *(Can be entered into TIMS)*

_____ ____/_____/____

Completed By Date